TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone and Joint Center

Respondent Name
Continental Casualty Co

MFDR Tracking Number
M4-16-0874-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In order to be sure that the patient is in compliance with the treatment plan as set up for him/her and in compliance with the Official Disability Guidelines, it is our protocol of care to perform random drug screens at an intermediate risk level. Which the ODG states a 3-4 time a year frequency is recommended for patients at intermediate risk."

Amount in Dispute: $3,441.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has maintains the denial of the bill as our position is the provider is billing incorrectly. …the drug screen is allowed once per patient per encounter and that was paid."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2015	Urinary Drug Screens	$3,441.03	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medial Fee Guideline

- 226 – Information requested from the billing rendering provider was not provided or not provided timely or was insufficient/incomplete
- 612 – No payment is made as Medicare uses another code for reporting and or payment of this service
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 612 – "No payment is made as Medicare uses another code for reporting and or payment of this service." 28 Texas Administrative Code §134.203(b)requires that

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas…

   Review of the submitted information finds the following;

Date of service	Submitted Code	Units	Amount billed	Code found on 2015 Clinical Diagnostic Laboratory Fee Schedule?
May 20, 2015	80346	1	$532.14	NO
May 20, 2015	80361	1	$401.10	NO
May 20, 2015	80364	1	$320.88	NO
May 20, 2015	80336	1	$271.68	NO
May 20, 2015	80368	1	$223.38	NO
May 20, 2015	80370	1	$221.61	NO
May 20, 2015	80373	1	$148.92	NO
May 20, 2015	80372	1	$148.92	NO
May 20, 2015	80367	1	$148.92	NO
May 20, 2015	80324	1	$128.16	NO
May 20, 2015	80365	1	$80.22	NO
May 20, 2015	80356	1	$80.22	NO
May 20, 2015	80348	1	$80.22	NO
May 20, 2015	80354	1	$74.46	NO
May 20, 2015	80366	1	$74.46	NO

May 20, 2015	80332	1	$74.46	NO
May 20, 2015	80349	1	$74.46	NO
May 20, 2015	80358	1	$67.35	NO
May 20, 2015	80359	1	$64.08	NO
May 20, 2015	80360	1	$64.08	NO
May 20, 2015	80353	1	$62.49	NO
May 20, 2015	80355	1	$54.27	NO
May 20, 2015	80345	1	$44.55	NO

These codes were not valid on the date of service as indicated above. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code §134.203 (e) states,

> The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
>
> > (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
> >
> > (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement (MAR) for the remaining services in dispute is 125% of the fee listed for the codes in the 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov.

Code 83992 – Allowable $20.00 x 125% = $25.00

Code G0434 – Allowable $15.13 x 125% = $18.91

The total allowable is $43.91. The carrier previously paid $55.16. No additional payment is due.

3. Pursuant to Rule 134.203 no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.